No. 84-325
No. 84-356

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY
Appellant,
v.
COMMONWEALTH OF MASSACHUSETTS,
Appellee.
No. 84-325

THE TRAVELERS INSURANCE COMPANY,
Appellant,
v.
COMMONWEALTH OF MASSACHUSETTS,
Appellee.
No. 84-356

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

BRIEF AMICUS CURIAE FOR THE STATE OF OREGON

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INTEREST OF AMICUS CURIAE STATE OF OREGON

This amicus curiae brief is submitted by the Attorney General of the State of Oregon on behalf of the state and its Insurance Commissioner. Pursuant to Rule 36 of the Rules of the Supreme Court, Oregon files this brief in support of appellee, the State of Massachusetts.

Oregon has a comprehensive insurance regulatory scheme governing group health insurance policies issued by insurance companies and by health care service contractors. Three of Oregon's statutes currently are under challenge in litigation pending before the Ninth Circuit Court of Appeals.[1] Plaintiffs in that litigation, like the appellants in this case, urge that states are preempted from requiring mandatory minimum benefit coverage in group health insurance policies when those policies are purchased by an ERISA welfare benefit plan. The Court's decision in this appeal will bear directly on the resolution of the Oregon case, which has been stayed pending that decision.[2]

Oregon's interest, however, is not simply that of a party involved in related litigation. Because this case involves state regulation of group health insurance, it has important

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[1] The Oregon case is *Hill v. Driscoll*, Civ. No. 84-287. The plaintiffs who brought the challenge to Oregon's statutes have filed an amicus brief in support of the appellant insurance companies.

[2] The district court granted summary judgment for defendants and issued an order rejecting the argument that ERISA preempts state regulation of group health insurance benefits. (*See* Order, App. B). On appeal, the Ninth Circuit stayed the briefing schedule until this Court decides this case. (*See* Order, App. C).

implications for the states' roles in devising effective protection against those health care risks which the various states deem to be of particular concern. Invalidation of minimum benefit insurance regulations under an ERISA preemption theory would seriously dilute if not altogether deprive Oregon of its direct regulatory control in this area of vital state concern. Consequently, the state-federal balance struck by Congress in the McCarran-Ferguson Act would be radically altered. It has been the consistent legal policy of the State of Oregon to pursue renewed recognition and validation of the principles of federalism that form the core of our nation's governmental structure under the United States Constitution. Oregon appears in order to preserve congressionally sanctioned state prerogatives in the area of insurance regulation.

SUMMARY OF ARGUMENT

The State of Oregon joins in the arguments presented by the State of Massachusetts in support of the Massachusetts Supreme Court's decision that the Employee Retirement Income Security Act of 1974 (ERISA)[3] does not preempt state laws regulating group health insurance policy benefits. Oregon appears as amicus curiae to advance two supplemental arguments which, we believe, will aid the Court's understanding of the full scope and consequences of the broad preemption theory advanced by the appellants insurance companies.

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[3] Pub. L. No. 93-406; 88 Stat. 829; 29 U.S.C. §§ 1001-1381 (1975).

1. The practical consequences of appellants' preemption arguments are potentially extreme. The enforceability of state laws governing group policy benefits lies in the uniform application of those laws. Oregon's Insurance Commissioner does not review all policies issued to ensure their compliance with state law, nor could she realistically do so. Rather, she approves general policy forms in advance and relies on her power to investigate in response to complaints or other circumstances suggesting specific violations. The broad preemption of state laws regulating group health insurance policies purchased for an ERISA plan would result in a de facto dual regulatory scheme. That scheme would be difficult if not impossible to administer and to enforce. In good faith or otherwise, purchasers might represent erroneously that a policy will insure an ERISA plan. Neither insurers, the Insurance Commissioner nor the beneficiaries of the policy realistically could scrutinize and test those representations except through litigation. Because of the difficulty of determining whether a qualified ERISA welfare plan exists, state regulations would be easily circumvented.

Ultimately, the enforcement of state laws regulating group health insurance would at best be uneven and uncertain; at worst, the states might be forced out of this aspect of insurance regulation because of the potential to mislead the public and because of the undesirability of retaining laws that cannot be effectively enforced. The state's role in insurance regulation is likely to be impaired more fundamentally than appellants' preemption argument at first suggests. That

result is directly at odds with the express provisions of both ERISA and the McCarran-Ferguson Act, and with policies that favor state primacy in the field of insurance regulation.

2. Not all state laws regulating group health insurance coverage are like the Massachusetts regulation challenged in this case. Oregon, for instance, has a significant number of statutory provisions which regulate only provider reimbursement for otherwise insured benefits. These regulations do not mandate coverage of particular benefits; rather, they ensure that state licensed professionals qualified to provide covered health services (*e.g.*, nurse practitioners) are not refused reimbursement if an insured prefers to obtain such services from such a professional rather than a physician. One of these categories of statutes has been challenged in Oregon on the same ERISA preemption theory presented here. However, arguments relating to the cost impact of state regulation on ERISA plans cannot be even colorably advanced against this type of statute. Even assuming the Court agrees with the preemption theory advanced in this case, the decision should reach only state regulation similar to that of the Massachusetts statute before the Court.

ARGUMENT

Appellants allege that section 514 of the Employee Retirement Income Security Act (ERISA) preempts application of state laws mandating minimum benefits for the beneficiaries of group health insurance policies. The issue arises when the trustees of an ERISA-qualified employee welfare benefit plan deem it inadvisable to self-insure the plan and instead seek to

gain an economic advantage from the broader risk distribution available through commercially marketed health care insurance.

As the State of Massachusetts demonstrates in its brief, the broad construction of the ERISA preemption clause urged by appellants is unsound. To so construe section 514(a) would be contrary to the express savings clause of section 514(b)(2)(A), and would render that subsection meaningless. Moreover, preemption of state mandatory benefit laws would be at direct odds with the express policy and provisions of the McCarran-Ferguson Act.[4] Finally, preemption would lead to the anomalous result that ERISA would invalidate state regulation of an aspect of ERISA plans (*i.e.*, the type and level of benefits) not regulated at all by ERISA, and not designed to be free of regulation.

The State of Oregon joins in the arguments presented by the State of Massachusetts, and will not repeat them. We appear in order to advance two discrete points only. First, we are concerned with the eventual practical consequences of the broad preemption theory presented to the Court. Realistically, if state regulations mandating minimum benefits in health insurance policies cannot be uniformly enforced, the danger is that they will not be enforced at all. Our second point is that not all state statutes regulating health insurance benefits are similar in their operation. The policy-based arguments urging that mandatory minimum

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[4] Pub. L. No. 79-15; 59 Stat. 33 (1945); 15 U.S.C. §§ 1011-1015 (1976).

benefit laws impose burdensome costs on ERISA welfare benefit plans are wholly inapplicable to many of the state laws regulating health insurance coverage and reimbursement provisions.

We make these points to demonstrate that federalism is not an abstraction in this case. The states in fact are active in the area of insurance regulation; their role is both pervasive and vital. Through a wide array of laws directed to health insurance benefits, the states have been able to address important contemporary local health issues and to improve significantly the quality of health care insurance provided to the public generally. The McCarran-Ferguson Act expressly calls on the states to play the primary role in regulating insurance. The provisions of ERISA expressly disavow that states should be divested of this role. The federal Health Maintenance Organization Act preserves for the states a complimentary regulatory function even in the federally crafted health care delivery scheme. In short, the federalism we urge the Court to preserve is real. Altering the current state-federal balance would impede seriously national efforts to improve the health of all citizens.

I. ERISA preemption of state laws regulating the contents of group health insurance policies may render such provisions unenforceable with respect to all group health policies, not only those purchased to insure ERISA employees.

The manner in which the Oregon Insurance Commissioner administers and enforces the group health policy reg-

ulatory scheme is, we believe, fairly typical of the states generally.[5] Importantly, it demonstrates that enforceability is largely a consequence of predictability and uniformity in the application of such regulations.

The Oregon Insurance Commissioner's ability to force insurance companies and other health care providers to comply with state insurance laws derives essentially from her power to authorize such insurers to do business within the state, and to revoke such authorization. In Oregon, no insurer can transact insurance except pursuant to a certificate of authority issued by the Commissioner. This requirement also exists for health care service contractors, which include federally approved health maintenance organizations (HMO's). The Commissioner has authority to investigate suspected violations of the Insurance Code and to take action for violations that ranges from entering cease and desist orders, to seeking court enforcement or restraint, and to revoking the requisite certificate of authority.[6]

The Oregon Insurance Commissioner does not ensure compliance with laws governing group health care insurance by reviewing the actual policies issued. Due to the volume of

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[5] *See* D. Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 59, 83 (1976), observing that most states require approval of group policy forms as a condition to marketing such policies by insurers, a system similar to that described here for Oregon.

[6] *See* Or. Rev. Stat. §§ 731.354 (issuance of certificate); 731.236(3) (investigative authority); 731.252 (cease and desist orders); 731.256 (institute actions for enforcement); 731.356 (file actions for restraint); 731.418(1)(a) (suspend or revoke certificates). The Commissioner's authority in all of these respects extend to health care service contractors. Or. Rev. Stat. § 750.005.

transactions in the insurance business, such review simply is not feasible. Instead, with few exceptions, the Insurance Commissioner approves in advance and retains on file all basic insurance policy forms which legally may be issued in Oregon. Or. Rev. Stat. § 743.006(1).[7]

The enforceability of state regulatory schemes mandating minimum benefit coverage in group health policies is thus largely dependent on the uniform application of such regulations. Insurers know precisely what every group policy must contain, and they must acquire pre-approval of many of those policies. They are unlikely to circumvent those requirements at the risk of losing their certificate to do business in the state. Members of the public may rely on the existence of state benefit laws to know with certainty their entitlement to specified coverage. The Insurance Commissioner can, also with certainty, advise individuals who inquire about state-mandated benefit protections. Further, she can provide information to the public generally about benefits mandated by state law. The regulatory system thus has a significant self-enforcing aspect: Because of its uniform scope and application, both the public and competitors within the insurance industry can better identify and report violations. In turn, the

[7] An exception exists for group health insurance policy forms agreed upon as a result of negotiations between the policyholder and the insurer. Or. Rev. Stat. § 743.006(1)(c). Ostensibly, these policies are exempted because their forms are unique and issued one time only; their filing as standard forms would serve no purpose. Whether policies purchased to insure an ERISA plan fall within the exemption depends on whether a standard group health policy is purchased or whether special policy provisions are negotiated between the insurer and the ERISA purchaser.

Commissioner can effectively investigate and establish violations, and sanction them.

A conclusion that ERISA preempts state minimum benefit laws when group health insurance is purchased for an ERISA welfare plan would result in a de facto dual regulatory scheme. State regulation would have full force in some instances and no force in others. The difficulty for insurers and the Insurance Commissioner would be to determine which purchases are for ERISA qualified plans, and which are not. There is no workable mechanism by which every group health insurance policy could be reviewed by the Insurance Commissioner to ensure that the purchaser is ERISA qualified. Even if there were such a mechanism, the determination simply could not be reliably made. Ascertaining the existence of a qualified ERISA plan is not within the scope of the Oregon Insurance Commissioner's authority, and certainly it is not within the scope of her expertise. Short of litigation, the responsibility for such a determination rests with the Secretaries of the United States Department of Labor and Department of the Treasury. *See* 29 U.S.C. § 1204. Significant controversy is generated over ERISA qualification questions, and they frequently are not susceptible of easy resolution. Often the courts must supply the answers. *See, e.g., Taggart Corp. v. Life & Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir.) *cert. denied*, 450 U.S. 1030 (1981) (multiple-employer insurance plan not within scope of ERISA); *Donovan v. Dillingham*, 688 F.2d

1367 (11th Cir. 1982) (some employers in multiple-employer insurance plan subject to ERISA, others possibly not).

Enforcement of a de facto dual regulatory scheme would be difficult at best. If a purchaser for a qualified ERISA plan were entitled to "pick and choose" among benefit options, there would be no effective way for the Insurance Commissioner to review whether the "optioning" was legal in a given instance. Without impugning the integrity of insurers or the insurance industry as a whole, there would be a substantial potential for abuse because unscrupulous competitors will write group health contracts without concern for mandatory benefit regulations once they perceive that the state cannot effectively police such contracts. Many insurance companies and health care service contractors no doubt will make every effort to comply with state regulation when appropriate, but they will be dependent on the representation of purchasers as to whether a policy is for a valid ERISA plan. The purchasers may not always be truthful or, if truthful, they may not always be correct. Ultimately, state regulation of group health insurance benefits may be either impractical or impossible. Rather than retain statutes which can be at best unevenly enforced and which may mislead the public about the scope of protection afforded to them, states may abandon regulatory efforts in this area altogether.

This result would be particularly anomalous in light of the federal Health Maintenance Organization Act, 42 U.S.C. § 300e. ERISA expressly states that it does not amend, alter, modify, invalidate, impair or supersede any other federal

law. *See* § 514(d). Appellants therefore cannot argue that the mandatory minimum benefit provisions of the Health Maintenance Organization Act are preempted by ERISA. Thus, if an employer seeks to contract with a federally qualified HMO to provide ERISA plan benefits, the employer must be willing to accept a contract covering benefits such as short-term mental health services and treatment for alcohol and drug abuse or addiction. *See* 42 U.S.C. §§ 300e(b)(1) and 300e-1(1). Moreover, the employer would also have to contract for such supplemental services as the HMO might require, such as vision care, dental care and prescription drugs. *See* 42 U.S.C. §§ 300e(b)(1) and 300e-1(2). The HMO Act is specific in listing the instances in which state law governing federal HMO's is preempted. Although the Act preempts any state laws which would frustrate an HMO's ability to do business because of requirements for initial capitalization and financial reserves, 42 U.S.C. § 300e-10(a)(1)(D), no similar preemption provision exists for state laws governing minimum benefits and coverage. Appellants should be particularly hard-pressed to urge that Congress wanted no state regulation of minimum group health benefits when Congress itself, in the case of federally approved HMO's, has mandated many such benefits and has permitted consistent state regulation of further minimum benefits.

The importance of state laws regulating benefit coverage for group health insurance policies should not be underestimated; the significance of a regulatory void if states are forced

to withdraw from this area cannot be understated. The advantage of group health insurance is that the underwriting unit is the entire group rather than each individual in the unit. Group plans thus maximize the essential quality of all insurance: The ability to transfer and distribute risk of loss among many individuals. Because they enjoy certain economies of scale and the elimination of administrative costs and commissions, group policies offer lower premiums and frequently greater risk coverage. State laws mandating that all group health insurance policies provide certain specified benefits permit state officials to identify important health dangers and to distribute the risk of their occurrence among a broad pool of citizens. Through this vehicle, states can address illnesses traditionally ignored by the insurance and health care provider industry (*e.g.*, alcoholism, mental illness); they can distribute the economic risk of conditions that are expensive to treat but less common in their occurrence (*e.g.*, maxillofacial prosthetic services for infants, which result in treatment of cleft palates and similar birth defects);[8] and they can ensure availability of insurance protection to individuals who sometimes are victims of societal ostracism (*e.g.*, unmarried pregnant women).[9] States thus may tailor insurance protections to local concerns, extend those protections to more citizens, and distribute the risk of certain health dangers among the broadest pool of beneficiaries possible.

[8] *See, e.g.*, Or. Rev. Stat. § 743.119.

[9] *See, e.g.*, Or. Rev. Stat. § 743.037, App. A.

To divest states of this regulatory function, even partially, would be directly contrary to express congressional policy and to a correct state-federal balance of authority over the business of insurance. For purposes of this amicus brief, a full recitation of the historical genesis of the McCarran-Ferguson Act is neither appropriate nor necessary. Rather, it should be sufficient to observe that the Act was passed in 1945 to ensure that courts would not invalidate state laws regulating insurance on the theory that they burden interstate commerce. To this end, section 1 of the Act expressly declared the continued regulation by the several states of the business of insurance to be in the public interest; section 2(a) of the Act provided that the business of insurance should be subject to all state laws relating to the regulation of insurance; and section 2(b) of the Act declared that no act of Congress shall be construed to invalidate, impair, or supersede any state law enacted to regulate the business of insurance unless the act specifically relates to the business of insurance.

This Court has construed broadly the concept of state laws regulating the "business of insurance." The concept includes not only laws directly or indirectly governing the relationship between the insurer and insured, but also regulation of the type of policy that can be issued, its reliability, its interpretation and its enforcement. *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

In the years since its enactment, the language of the McCarran-Ferguson Act has not been changed signifi-

cantly. Similarly, the congressionally declared policy of state primacy in the area of insurance regulation has not been diluted even slightly. The reasons for striking the state-federal balance of authority in favor of local regulation and control remain compelling. ERISA reinforces the policy of state primacy rather than questions it by its so-called "savings clause," section 514(b)(2)(A). That clause expressly and unequivocally declares that the ERISA provisions shall not be construed to exempt or relieve any person from any state law regulating insurance. Together, the McCarran-Ferguson Act and section 514(b)(2)(A) of ERISA manifest an unmistakable acknowledgment that the regulation of insurance remains a vital state concern and that it is broadly in the public interest for states to play an active and primary regulatory role.

ERISA preemption of state-mandated benefits for group health insurance would undermine this manifestation of congressional intent. Moreover, if states withdraw from this area of insurance regulation altogether because of difficulty in enforcing a de facto dual regulatory scheme, the congressional policy favoring state insurance regulation would be more seriously breached than appellants' arguments first suggest. Those arguments therefore forcefully should be rejected.

II. Many state regulations governing group health insurance coverage do not mandate particular benefits, and thus have no potential to increase significantly the cost of insuring an ERISA plan.

This case involves a challenge to the Massachusetts law mandating mental health coverage under certain group or

blanket health care insurance policies. Because this statute requires coverage that might not otherwise be provided by an ERISA plan, both appellants and their amicus have attempted to argue that such state laws severely burden ERISA plans with added costs.[10] This cost impact argument was found by the Massachusetts trial court to be speculative and wholly unsupported by the evidence.[11] It therefore should not concern this Court in resolving the issue presented.

Nevertheless, whatever the worth of the cost impact argument, it falls of its own weight when tested against other types of state regulatory provisions. Oregon has several laws that focus on reimbursement to specific classes of providers rather than on the requirement that certain services be covered by a group insurance policy. We assume such statutes are not unique to Oregon. Indeed, the Federal Health Maintenance Act, *supra*, contains provisions allowing HMO's to provide services through professionals, other than physicians, licensed by a state to provide covered services. *See* 42 U.S.C. § 300e-1(1), (2). These types of statutes, in effect, merely require reimbursement to professionals licensed to perform certain health care services if a policy would reimburse a physician for the same service; they do not themselves require that particular health care services be covered by a policy.

Oregon has several examples of this type of regulatory provision. Psychologists must be reimbursed when they pro-

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[10] *See* Appellants' Br. pp. 23-26 and *see generally* Amicus Brief for the Trustees of Local 16.

[11] *See* J.S. App. 54a-55a.

vide a service within the scope of their professional license if the service is one covered by the terms of a group health insurance policy. Or. Rev. Stat. § 743.123. Reimbursement is not dependent upon referral by a physician. Oregon law also provides that covered services within the scope of practice of a licensed nurse practitioner must be reimbursed whether the service is performed by a physician or by a nurse practitioner. Or. Rev. Stat. § 743.128. Additionally, in Oregon, if a policy covers services within the scope of practice of a licensed clinical social worker, the insured may, upon referral by a physician or psychologist, obtain the service from a licensed clinical social worker and be reimbursed. Or. Rev. Stat. § 743.135. This last statute is among the three challenged by the plaintiffs in *Hill v. Driscoll*, on an ERISA preemption theory. Because other statutes operate similarly to mandate payment for the services of state hospital or community mental health programs (Or. Rev. Stat. § 743.116), services of optometrists (Or. Rev. Stat. § 743.117), and services of denturists (Or. Rev. Stat. § 743.132), a significant number of Oregon statutes will be preempted if the Oregon plaintiffs prevail.[12]

Regulations of this type, however, do not establish minimum benefit coverage and cannot be challenged as burdensome to the cost structure of an ERISA plan. Provider reimbursement statutes like these in Oregon do not force an

[12] The relevant texts of these statutes are set out in Appendix A.

insured to seek insured health services from a specific category of provider (*e.g.*, a clinical social worker rather than a psychologist; a denturist rather than a dentist); they merely permit the insured the option to do so. There is no reason to believe that the cost of health benefits or their scope will be increased. Indeed, if anything, allowing insurance beneficiaries the option of going to licensed health care professionals other than physicians likely is cost-effective. Enactment of regulation of this type promotes the state's interest in the integrity of its licensing scheme for health care professionals. Neither ERISA plan trustees, insurance companies nor other health care service contractors (*e.g.*, Blue Cross/Blue Shield) should be permitted to use provider restrictions in health care policies to favor some professions over others, with the possible practical effect of driving certain providers out of the market and overriding a state's professional licensing scheme.

We recognize that the controversy currently before the Court does not involve statutes of this nature. Nevertheless, as the Oregon litigation demonstrates, they are subject to the same sort of ERISA preemption challenge as is made against the Massachusetts law mandating mental health coverage. In resolving the Massachusetts case, it is appropriate for this Court to be aware of the full depth, breadth and variety of state regulation that possibly will be affected by the Court's decision. Appellants' ill-supported assertions that mandatory benefit regulations impose burdensome costs on ERISA plans

are wholly inapplicable to state provider reimbursement regulations, and perhaps other forms of state insurance regulations as well.

We therefore urge this Court to consider the full range of state insurance laws potentially affected by the Court's decision and to craft its decision accordingly. Alternatively, we urge the Court to tailor its decision carefully to the specific type of statute before it and to make express the circumscribed scope of its holding.

CONCLUSION

Directly at stake in this case is state authority to regulate group health insurance coverage when an insurance policy is purchased to provide health care under an ERISA benefit plan. Potentially at stake is the practical ability of states to administer and to enforce state laws ensuring specific types of health care protection in group policies if to do so requires them to distinguish between ERISA and non-ERISA purchasers. Finally, implicated in this case is the validity of many other state laws, such as provider reimbursement provisions, which regulate group health insurance policies in distinguishable ways, and thus present distinguishable policy considerations. The effect of the appellant insurance companies' preemption argument would be far reaching and would seriously interfer with state prerogatives in the regulation of insurance. That effect is squarely contrary to declared congressional intent and to sound national policy. The broad ERISA preemption argument presented therefore should be

rejected and the judgment of the Massachusetts court should be affirmed.

Respectfully submitted,

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APPENDIX A
SELECTED OREGON REVISED STATUTES
INSURANCE POLICIES

743.037 Nondiscriminatory health insurance coverage for women. Each policy of health insurance shall provide:

(1) The same payments for costs of maternity to unmarried women that it provides to married women, including the wives of insured persons choosing family coverage; and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives.

743.116 Reimbursement for services performed by state hospital or state approved program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program.

743.117 Reimbursement for services of optometrist. (1) Notwithstanding any provision of any policy of health insurance, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether such service is performed by a physician or duly licensed optometrist. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) The provisions of this section shall not apply to any policy in effect upon September 13, 1967.

743.123 Reimbursement for services provided by psychologist. Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675.010 to 675.150:

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675.010 to 675.150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice.

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to him or on his behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675.010 to 675.150.

743.128 Reimbursement for services of nurse practitioner. (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the

Board of Medical Examiners for the State of Oregon or by a duly licensed nurse practitioner.

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act.

743.132 Reimbursement for services of denturist. Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a certified denturist. This section shall apply to any policy covering dental insurance which is issued after July 1, 1980. Policies which are in existence on July 1, 1980, shall be brought into compliance on the next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest.

743.135 Reimbursement for services of clinical social worker. Whenever any individual or group health insurance policy provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker registered under ORS 675.510 to 675.610:

(1) The insured under the policy shall be entitled to the services of a clinical social worker registered under ORS 675.510 to 675.610, upon referral by a physician or psychologist.

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

MILTON R. HILL, RICHARD J. MIXER, LEONARD ROTHENBERGER, JAMES A. ARCHER, DOUGLAS McQUOWN, and RICHARD RALSTON, Trustees of Sheet Metal Workers Local 16 Health & Welfare Trust,	)	Civil No. 84-287
Plaintiffs,	)	ORDER
v.	)	
JOSEPHINE M. DRISCOLL, Insurance Commissioner of the State of Oregon, and BLUE CROSS AND BLUE SHIELD OF OREGON, a corporation,	)	
Defendants.	)	

This is an action for declaratory and injunctive relief brought by the trustees of the Sheet Metal Workers Local 16 Health and Welfare Trust (the Trust). Established by a collective bargaining agreement, the Trust receives contributions from employers pursuant to an employee benefit plan (the Plan). The Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*

Defendant Josephine Driscroll is the insurance commissioner for the state of Oregon. Defendant Blue Cross and Blue Shield of Oregon (Blue Cross) is a corporation that sells and issues group insurance policies. Blue Cross is an authorized health care service contractor subject to state regulation.

The Oregon insurance code requires that group health insurance policies contain coverage for: 1) treatment of chemical dependency, including alcoholism; 2) services by a registered clinical social worker; and 3) maxillofacial prosthetic devices. Or. Rev. Stat. §§ 743.110 [*sic*], 743.135, 743.557. The benefits provided by the Plan do not include coverage as required by these provisions. The trustees of the Plan wish to provide health care coverage under the Plan by purchasing a group health insurance policy from Blue Cross, but Blue Cross maintains that any policy it issues must contain the mandated coverage.

The plaintiffs seek a judgment declaring that, on the basis of federal preemption by ERISA, the Plan, the Trust and the trustees are not subject to the mandated insurance coverage of the Oregon statutes. The plaintiffs also seek an order restraining the insurance commissioner from attempting to require the Plan to provide the mandated insurance coverage. The defendants contend that all group policies sold by authorized insurers must comply with the Oregon statutes, regardless of whether the purchaser of a group policy is an ERISA plan. Both parties move for summary judgment.

Discussion

The preemption provisions of ERISA are found at 29 U.S.C. § 1144. The general preemption clause states that ERISA supersedes "any and all state laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a).

The general preemption clause is modified by a "savings clause" that affirms state authority to regulate insurance. The savings clause exempts from preemption any state law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A).

The savings clause is in turn limited by the "deemer clause," which provides that a state may not deem a benefit plan to be an insurance company or other insurer or to be engaged in the business of insurance in order to subject a plan to state insurance regulation. 29 U.S.C. § 1144(b)(2)(B).

The issue presented here requires analysis as follows: 1) whether the Oregon statutes "relate to" the Plan and so are subject to the general preemption clause; 2) if so, whether the statutes are exempt from preemption under the savings clause as laws which "regulate insurance;" and 3) if so, whether the deemer clause requires preemption nevertheless.

The defendants concede that the statutes at issue here "relate to" employee benefit plans and are subject to the general preemption clause. However, the defendants contend that the Oregon statutes are laws which "regulate insurance," expressly exempted from preemption by the savings clause.

ERISA contains no definition of the phrase "regulate insurance." However, in *SEC v. National Securities, Inc.*, 393

U.S. 453-(1969) the Supreme Court defined the scope of state laws "regulating the business of insurance" as those which deal with "[t]he relationship between insurer and insured, *the type of policy which could be issued*, its reliability, interpretation and enforcement. *Id.* at 459-60 *Quoted in Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980) (emphasis added).

The Oregon statutes are directed solely at insurance companies and govern the terms of insurance policies. The statutes are laws which "regulate insurance" and are subject to the savings clause.

The conflict between preemption of the statutes by the general preemption clause and exemption under the savings clause must be resolved by application of the deemer clause.

The deemer clause restricts application of the savings clause by prohibiting the state from deeming a benefit plan to be an insurer in order to subject the plan to insurance regulation. On its face, the deemer clause does not forbid insurance regulation which has only an indirect effect on employee benefit plans. However, some courts have held that there is no difference between direct and indirect regulation of employee benefit plans, and that both types of regulation are proscribed by ERISA. *See, e.g., United Food and Commerical Workers Unions v. Baerwaldt*, 572 F. Supp. 943 (E.D. Mich. 1983).

But I find more persuasive the court's analysis in *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). In *Wadsworth*, the court held that a New Hampshire statute which required that issuers of

group health insurance policies provide coverage for the treatment of mental and emotional illnesses was not preempted by ERISA. The court reasoned that a construction of the deemer clause which barred even insurance regulation with an indirect effect on employee benefit plans would render the savings clause surplusage. 562 F.2d at 78. In *Eversole*, *supra*, the court arrived at the same conclusion. The *Eversole* court emphasized the "fundamental" distinction between laws regulating an employee benefit plan and laws regulating the insurance company from which the plan purchases insurance. 500 F. Supp. at 1169. *See also, Hewlitt-Packard Co. v. Barnes*, 571 F.2d 502, 504-05 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (direct regulation of employee benefit plans prohibited). The *Eversole* court noted that since only insurance laws that "relate to" employee benefit plans are even subject to ERISA preemption, "if insurance regulation which has an indirect effect on employee benefit plans is preempted by the deemer clause, what is left for the savings clause to save?" *Id*; *McLaughlin v. Connecticut General Life Ins. Co.*, 565 F. Supp. 434, 443 (N.D. Cal. 1983) (adopting *Wadsworth*, and *Eversole* analysis).

When interpreting an act of Congress, the court is required to construe it so as to give effect to all its parts. *See e.g., McDonald v. Thompson*, 305 U.S. 263 (1938). I therefore conclude that Or. Rev. Stat. § 743.110 [*sic*], 743.135, and 743.557 are not preempted by ERISA.

IT IS ORDERED that plaintiffs' motion for summary judgment is denied. Defendants' motion for summary judgment is allowed.

Dated this 7th day of September, 1984.

[Signature omitted in printing]

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MILTON R. HILL, et al.,	)	No. 84-4223
	)	
Plaintiffs-Appellants,	)	DC# CV-84-287 EL
	)	Oregon (Portland)
vs.	)	
	)	
	)	
JOSEPHINE M. DRISCOLL, Insurance Commissioner of the State of Oregon, et al.,	)	ORDER
	)	
	)	
	)	
	)	
Defendants-Appellees.	)	
	)	

On November 29, 1984, a Prebriefing Conference was held before Conference Attorney Randall G. Knox. Plaintiffs were represented by James Clarke. The State of Oregon was represented by Linda DeVries. Blue Cross was represented by Jack Hoffman.

This appeal is stayed until June 1, 1985 or pending the Supreme Court's disposition of *Travelers Insurance Co. v. Commonwealth*, 84-356, (probable jurisdiction noted), whichever occurs first.

Plaintiffs shall contact the Conference Attorney upon expiration of the stay to schedule a further prebriefing conference, if necessary.

This order is subject to reconsideration by a judge if any objection is filed within 10 days of the entry of the order.

[Signature omitted in printing]